Refine Search

Search Results -

Terms	Documents
L3 and (state or rul43 or regulat$3)	3

Database: US Pre-Grant Publication Full-Text Database; US Patents Full-Text Database; US OCR Full-Text Database; EPO Abstracts Database; JPO Abstracts Database; Derwent World Patents Index; IBM Technical Disclosure Bulletins

Search: L4

Refine Search | Recall Text | Clear | Interrupt

Search History

DATE: Sunday, October 15, 2006 **Purge Queries** Printable Copy Create Case

Set Name side by side	Query	Hit Count	Set Name result set
	DB=PGPB,USPT; PLUR=YES; OP=ADJ		
L4	L3 and (state or rul43 or regulat$3)	3	L4
L3	L1 and (insolvenc$3 or risk$6 or loss$3) near20 insurance	4	L3
L2	L1 and line near20 insurance near20 account	1	L2
L1	(5704045 or 6119093 or 6604080 or 20020035488).pn.	4	L1

END OF SEARCH HISTORY

L4: Entry 2 of 3 File: USPT Aug 5, 2003

DOCUMENT-IDENTIFIER: US 6604080 B1
TITLE: Computer system and methods for supporting workers' compensation/employers liability insurance

Brief Summary Text (8):
II. DESCRIPTION OF THE RELATED ART A. Overview B. Basic Nature of Workers' Compensation C. Different Approaches Used by Different States 1. State Funds a. Monopolistic State Fund b. Competitive State Fund 2. Standard Workers' Compensation Policy i. NCCI Role in the Standard Workers' Compensation Market ii. Analysis of a Standard Workers' Compensation Policy iii. Workers' Compensation Assigned Risk Plans Under a Standard Workers' Compensation Policy iv. Disadvantages of a Standard Workers' Compensation Policy 3. Self-Insurance a. Group Self-Insurance b. Individual Self-Insurance 4. Twenty-Four Hour Coverage 5. ERISA D. Summary of the Prior Art III. SUMMARY OF THE INVENTION A. An Innovative Financial Product B. A Computerized Rating System IV. SUMMARY OF THE DRAWINGS V. DETAILED DESCRIPTION OF A PREFERRED EMBODIMENT OF THE INVENTION AND ITS BEST MODE VI. CLAIMS

Brief Summary Text (14):
In contrast, employers liability insurance, which appears to have been first undertaken in England and which apparently was recognized in America until about 1887, is a contract. Under an employers liability insurance contract, a consideration, or a premium (which is usually based upon or bears a direct ratio to the gross amount of wages paid by the insured), is paid for a specified term to insure an employer against liability for damages on account of bodily injuries, fatal or nonfatal, accidentally suffered by an employee. Under this kind of insurance, the insurer agrees to indemnify the employer for the loss or damage actually sustained by reason of the employers liability to an employee for such an injury or death. See Cyclopedia of Insurance Law.

Brief Summary Text (17):
Statutory efforts known as "employers liability laws" were made to diminish or remove some of the employers common-law defenses so that the injured worker would stand a better chance in court. This legislation could be classified in three categories: (1) statutes denying the right of employers and workers to sign contracts relieving the employer of liability for accidents as a condition of employment, and twenty-seven states had legislated against such practice by 1908; (2) statues extending the right of suit in death cases, and by 1904, 41 jurisdictions had such statutes; and (3) statutes abrogating or modifying the common-law defenses. But by the end of the nineteenth century, a coincidence of increasing industrial injuries and decreasing remedies had produced in the United States a situation ripe for radical change. Thus, when a full account of a German system for compensating injured employees, written in 1893 by John Graham Brooks, was published as the Fourth Special Report of the Commissioner of Labor, legislators all over the country seized upon it as a cue to the direction which efforts at reform might take. Workers' Compensation Law: Cases, Materials and Text, by Arthur Larson, published in 1984 by Mathew Bender, New York, N.Y. For example, the Federal Employers Liability Act, adopted in 1908 and applicable to railway employees engaged in interstate commerce, amounted to a codification of statutory improvements up to that time and was an important step forward.

Brief Summary Text (18):
In Chicago in 1910, a conference was attended by representatives of the commissions of the legislatures of Massachusetts, Minnesota, New Jersey, Connecticut, Ohio, Illinois, Wisconsin, Montana, and Washington. And at that conference, a Uniform Workers' Compensation Law as drafted. Although the state acts which followed were anything but uniform, the discussions at this conference did much to set the fundamental pattern of legislation. See Workmen's Compensation--Prevention, Insurance and Rehabilitation of Occupational Disability, by Herman Miles Somers, Anne Ramsey Somers, published by John Wiley & Sons, Inc., New York, and Chapman & Hall, Limited, London.

Brief Summary Text (19):
As to actual enactments, the first New York act was passed in 1910. The act had compulsory coverage of certain "hazardous employments." However, the act was held unconstitutional in 1911 by a Court of Appeals, on the ground that the imposition of liability without fault upon the employer was without due process of law under the state and federal constitutions.

Brief Summary Text (20):
Eventually, the law came to recognize an important legislative agreement, and a compromise between employers and workers provided the framework for workers' compensation laws in the United States. Employers agreed to pay benefits to all workers who became disabled or died as the result of an injury that arose out of, and in the course of, employment. Workers agreed to accept workers' compensation as the exclusive remedy against their employers.

Brief Summary Text (22):
Workers, in turn, are guaranteed protection from the economic loss and the financial burdens of medical and rehabilitation care that frequently accompany injury. For them, workers' compensation provides a convenient, minimally adversarial, and speedy benefit delivery mechanism. No longer do the vagaries of tort law apply to workers whose ability to work is impaired or terminated as a result of an employment-related injury. Contributory negligence, assumption of risk, and fellow employee doctrines of fault have no effect on a worker's ability to recover under workers' compensation. This protection generally extends to all covered workers solely because of the existence of an employer/employee relationship. The U.S. Supreme Court observed in Cudahay Packaging Co. v. Parramore, 263 U.S. 418 (1924) that: "This liability is based, not upon any act or omission by the employer, but upon the existence of the relationship which the employee bears to the employment because of and in the course of which he has been injured." See generally, The Constitutionality of Compulsory Workmen's Compensation Acts, by Samuel B. Horovitz and Josephine H. Klein, reprinted from Proceedings, International Association of Industrial Accident Boards and Commissions, Twenty-fifth Annual Convention, Charleston, W. Va., Sep. 26-29, 1938. Bulletin No. 26 United States Department of Labor, Division of Labor Standards.

Brief Summary Text (23):
Presently, the constitutionality of compensation acts in various states is clearly and firmly established. However, in the evolution of court decisions to achieve constitutionality of the workers' compensation scheme, there evolved a lack of uniformity of coverage in the United States. Some states limit their acts to hazardous industries only and omit all others; many omit farm laborers and domestic servants; others make it compulsory as to all public employment, and elective as to private employments. See Issues in Insurances--Volume I--Everett Randall.

Brief Summary Text (25):
Workers' compensation provides cash benefits and medical care to victims of work-connected injuries. There is a workers' compensation act in each of the 50 states; no two are exactly alike, but many of the basic features of these acts are similar, as outlined in this section.

Brief Summary Text (30):
Most states not only prescribe the nature of the injuries that are to be compensated and the size of the benefits, but also administer the program. There is usually an administrative agency which supervises the handling of the injured workers' cases and adjudicates any dispute concerning the eligibility for benefits and the extent of the injuries. Normally, the state's judicial system becomes involved in the law of workers' compensation only when a decision of the workers' compensation agency is appealed. Many states also provide vocational or medical rehabilitation services for injured workers, but this is not technically a part of the workers' compensation system.

Brief Summary Text (31):
Despite the involvement of the states in certain aspects of the workers' compensation program, it nonetheless remains a system which is basically privately run. The workers' compensation statute indicates that each employer shall compensate injured workers by a certain formula of benefits, but the decision of how these benefits are to be provided is usually a decision for the employer. See generally, Interstate Variations in Employers' Costs of Workmens' Compensation, Effect on Plat Location Exemplified in Michigan by John F. Burton, Jr. (A Study of the Institute of Labor and Industrial Relations--The University of Michigan--Wayne State University), published by the W. E. Upjohn Institute for Employment Research.

Brief Summary Text (32):
C. Different Approaches Used by Different States

Brief Summary Text (33):
With each state passing its own workers' compensation scheme, different approaches were created to allow employers to meet statutory obligations to provide workers' compensation. Most states passed a compulsory compensation law; a compulsory compensation law requires every employer to accept the act and pay the compensation as specified. In contrast, New Jersey, South Carolina, and Texas provide for an "elective act," whereby the employer has the option to accept or reject the act, but if the employer rejects the act, the employer will be precluded from raising the common-law defenses of assumption of risk, negligence of fellow servants, and contributory negligence.

Brief Summary Text (34):
With regard to insuring against an employers workers' compensation obligation, there are five basic methods: (1) state funds; (2) a standard workers' compensation insurance policy; (3) self-insurance; (4) Twenty-Four Hour Coverage insurance policies and (5) ERISA plans.

Brief Summary Text (35):
1. State Funds

Brief Summary Text (36):
a. Monopolistic State Fund

Brief Summary Text (37):
A monopolistic state fund basically requires the employer to buy workers' compensation coverage from the state. For example, the State of Nevada allows individual self-insurance but has a required state fund. The states of Ohio, Washington, and West Virginia permit self-insurance, but have a required state fund. The states of North Dakota and Wyoming do not permit self-insurance and have a required state fund. See 1991 Analysis of Workers' Compensation Laws, prepared and published by the U.S. Chamber of Commerce.

Brief Summary Text (38):

In summary, four of the six state fund states allow eligible employers to self-insure or to use the state fund only. North Dakota and Wyoming allow the employer to be insured for the workers' compensation obligation only through the state fund. No other alternatives are accepted. Thus, a standard workers' compensation policy is not available to be sold in the above states.

Brief Summary Text (39):
b. Competitive State Fund

Brief Summary Text (40):
Sixteen states appear to presently offer insurance coverage for workers' compensation through a state fund that competes with the private market. Some of the states included are Arizona, California, Colorado, Idaho, Maryland, Michigan, Minnesota, Montana, New York, Oklahoma, Oregon, Pennsylvania, and Utah. While the monopolistic state fund approach, with the few exceptions noted above, is the only method of securing compensation, those states with a competitive state fund allow the employer the choice to seek workers' compensation coverage through either the state fund or the private insurance marketplace. In October 1991, Louisiana passed a state consitutional amendment allowing it to have a competitive state fund.

Brief Summary Text (41):
The breakdown in each of these states as to what that private insurance marketplace consists of is as follows. Arizona, Michigan, New York, Oklahoma, and Oregon allow individual and group self-insurance and the sale of a standard workers' compensation policy; Maryland permits individual and group self-insurance but group self-insurance is limited to counties, municipalities, and certain private employers, and it also allows the sale of a standard workers' compensation policy; Minnesota permits individual and group self-insurance and allows public corporations and state agencies to establish individual or group self-insurance funds, and it also allows the sale of a standard workers' compensation policy; California, Idaho, Pennsylvania, and Utah permit self-insurance and the sale of a standard workers' compensation policy. 1991 Analysis of Workers' Compensation Laws, prepared and published by the U.S. Chamber of Commerce.

Brief Summary Text (43):
The standard workers' compensation policy, which can be issued in 44 states (those without a state fund), is a way by which an insurance company insures the employer against its workers' compensation obligation and its employers liability obligation. That is, the standard workers' compensation policy has two parts. Part A covers workers' compensation, while part B covers employer liability: It is a single insurance policy. See Louisiana Workers' Compensation Review, prepared by Independent Insurance Agents of Louisiana.

Brief Summary Text (44):
In 1942, the Section of Insurance Law of the American Bar Association created a committee on workers' compensation and employers liability insurance law and put forth the "Standard Workers' Compensation and Employers Liability Policy." It is important to note that the standard workers' compensation policy combined both policies such that the standard policy is one policy of insurance. The foreword to that publication states "The Standard Workmans Compensation and Employers Liability Policy is dual in its purpose. It affords the insured (A) protection against liability under workers' compensation laws, and (B) protection against liability imposed by law for damages in cases where the Compensation Act does not apply." Policy Annotations from the Conference Commentary of the American Bar Association, Insurance Committee.

Brief Summary Text (45):
Traditionally, standard workers' compensation policies have been issued by "P & C" carriers. A "P & C" carrier, in the industry, is a property and casualty insurance company. That company is known as a property and casualty company because its

state-issued "certificate of authority" allows it to write lines of insurance covering property and lines of insurance covering casualty.

Brief Summary Text (46):
According to each state law, a charter may allow the insurance carrier to write many or different lines of insurance business. Each state has a workers' compensation law, but the laws are not identical. For example, Arkansas law provides that under Section 11-9-102 (15) "Carrier--means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized (emphasis added) to write or carry on the business of workers' compensation insurance in this state." But most states give the insurance commissioner of that state the power to authorize an insurance carrier, depending on its charter, a certificate to write workers' compensation insurance. Many states have statutes which allow "alternative equivalents" (i.e., other arrangements of insurance to satisfy the workers' compensation insurance requirements). However, at present, it is believed that many, if not all, states have allowed only standard workers' compensation policies to be issued by property and casualty insurance carriers.

Brief Summary Text (48):
Early in the development of the enactment of workers' compensation laws, there was a need for a body to coordinate insurance industry activities with the state governments and to provide a systematic determination of costs and a more uniform approach to workers' compensation. In response to this need, the National Council on Compensation Insurance ("NCCI") was founded as an organization of insurers (rather than rating bureaus) and became operational in 1923. At that time, it established prices for companies writing workers' compensation insurance in 10 jurisdictions. Today the NCCI is the largest workers' compensation insurance service organization in the United States; there are over 700 members or subscriber insurance companies and state funds utilizing the services of the NCCI. Each member carrier of the NCCI reports to the NCCI statistical information for the states in which the member carrier writes workers' compensation insurance. Member carriers also adhere to form and rate filings and pay charges and assessments levied against NCCI. NCCI makes rates for 32 jurisdictions and provides technical and production assistance to local statistical organizations in 14 additional jurisdictions. NCCI presently also administers assigned risk plans in over 23 jurisdictions. With regard to pricing of a standard workers' compensation policy (that single policy in which the first part covers workers' compensation and the second part covers employers liability), the NCCI serves as the primary workers' compensation pricing organization in most states.

Brief Summary Text (49):
It is important to note that there is a difference between being a member of NCCI and being a member of the National Re-insurance Pool. If an insurance company is a member of the latter, then the assessments and assignments are manded. Each state's law varies regarding whether a carrier issuing a standard workers' compensation policy must participate in this national Re-insurance Pool. For example, Louisiana law allows voluntary participation in the National Re-insurance Pool.

Brief Summary Text (52):
As previously stated, a standard workers' compensation policy insures two concrages in the same policy. Part A insures or indemnifies the employer for all of the statutory workers' compensation obligations which might otherwise be incurred from the suits by injured employees under the stat or states in which the employer does business. Part A covers practically all work-related injuries to employees, and liability is based on a "no fault" basis not on negligence. The workers' compensation statutory remedy is the exclusive remedy or payment to the injured employee.

Brief Summary Text (53):
The standard workers' compensation policy has a "we will pay" clause that states

"we will pay promptly when due the benefits required of you by the workers' compensation law." The standard workers' compensation policy also has a "conformity to satute" clause ("terms of this insurance that conflict with the workers' compensation law are changed by this statement to conform to that law"), which in essence says that the insurance carrier will indemnify the employer for the remedies which the injured employees has against the employer for workers' compensation under that particular state's law.

Brief Summary Text (54):
The standard workers' compensation policy, with its "we will pay" clause and "conformity to statute" clause, does not outline the benefits for the state where the policy is issued. Rather, it relies upon these clauses to conform to the benefits provided under that particular state's workers' compensation law.

Brief Summary Text (55):
Because a standard workers' compensation carrier is a property and casualty insurance company, most states have enacted laws which provide that an admitted property and casualty insurance company is backed by a state's Guaranty Association. A Guaranty Association, in the event of insolvency of the issuing insurance company, will pay the injured worker his or her workers' compensation, medical, disability or other payments.

Brief Summary Text (57):
Workers' compensation was the first compulsory insurance program adopted in the United States to be underwritten primarily by private insurers. But considerable agitation for state funds to provide the insurance accompanied the rising importance of workers' compensation. Advocates of state funds argued that they were needed to ensure insurer solvency and fair pricing.

Brief Summary Text (58):
Several states established such funds, but the coverage continued to be written by private insurers. As some private insurers began to evaluate the risks over time, based on loss history data, companies began to reject workers' compensation coverage for certain employers. When these employers were unable to obtain workers' compensation coverage, they lobbied their state legislatures, maintaining that because their particular industry was vital to that state, the state should require those insurance companies to write workers' compensation coverage or provide a method for them to get workers' compensation coverage.

Brief Summary Text (59):
In 1929, Minnesota adopted what appears to be the first statute requiring the insurance companies to provide coverage for applicants they did not want to insure. It required the workers' compensation rating bureau of Minnesota to assign a member company to provide coverage for any employer that had been refused coverage by three bureau members. It provided in part: "When any such rejected risk is called to its attention and it appears that said risks is in good faith entitled to coverage, said bureau shall fix the initial premium therefor, and upon its payment, such bureau shall designate a member whose duty it shall be to issue a policy containing the usual and customary provisions found in such policies therefor but for such undertaking all members of such bureau shall be reinsurers as among themselves in the amount which the compensation insurance written in this state during the preceding calendar year by such member bears to the total compensation insurance written in this state during the preceding calendar year by such member bears to the total compensation insurance written in this state during the preceding year by all the members of the said bureau."

Brief Summary Text (61):
The pro rata sharing of the mandated exposures among insurers on the basis of their shares of the business in the state has become the model for most other residual market plans. By 1936, workers' compensation assigned risk plans had been

established in sixteen states and the District of Columbia. Most of them were "voluntary plans," i.e., not mandated by state law. At that time, a reinsurance program was available so that insurers could reinsure those exposures assigned to them. The reinsurance was not compulsory, but the exposures were fully reinsured if the assigned insurer elected to participate. Typically, the ceding company retained 30 percent of the premium and paid the balance to the reinsurance pool. The assigned insurer provided all services to the insured employer, including a loss adjustment service. Whenever the premiums were inadequate to cover the losses, the reinsurance pool then reimbursed the insurer for all losses incurred and assessments levied on participating companies.

Brief Summary Text (62):
Workers' compensation assigned risk plans are now in operation in the District of Columbia and all states except California, Colorado, Idaho, Maryland, Montana, Nevada, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, and Wyoming. In the excepted states, the state funds are required to accept all applicants, so assigned risk plans are not necessary.

Brief Summary Text (64):
The workers' compensation assigned risk plans now operate in a manner quite similar to automobile assigned risk plans. Approximately forty servicing insurers issue all of the policies and provide all services to the insured employers and their employers. All exposures written under the plans by these servicing insurers are reinsured by the approximately 400 participating insures in proportion to their voluntary business in the respective states.

Brief Summary Text (65):
As a majority rule in the average state, the following scenario resulted regarding the assigned risk pool. The workers' compensation assigned risk plan was approved by that state's insurance rating bureau, insurance department, or commission as the method to provide workers' compensation insurance to an employer unable to obtain coverage in the voluntary market. The bureau, insurance department, or commission exercised regulatory power over the assigned risk plan, but selected the NCCI to administer the operation of the plan.

Brief Summary Text (66):
As mentioned earlier, the NCCI presently administers the assigned risk plan in over 23 jurisdictions. Insurance companies that belong to the NCCI joined as a member, subscriber, or service purchaser. By so joining, these companies designate that those states where they write workers' compensation accept as filings, on behalf of the insurance company, the policy and endorsement forms prepared and issued by the NCCI as "Standard" forms. If an insurance company belongs to the NCCI, it has the option to participate in the workers' compensation assigned risk plan.

Brief Summary Text (67):
Once an election to participate in the plan has been made, the company is then obligated to pay its pro-rata liability in the assigned risk plan for all states in which it writes workers' compensation insurance on a voluntary basis. The insurance company is not allowed to choose particular states in which they wish to operate; the carriers have to write in all or none of the states in which they write voluntary compensation business.

Brief Summary Text (72):
Companies knowing that every dollar of writings in the voluntary market creates significant liabilities and seeing no possibility of relief, are reluctant to write compensation insurance in Louisiana voluntarily. Companies not writing workers' compensation are not subject to an assessment, but if no company elects to write a workers' compensation policy where there will be no one to assess. What becomes of the assigned risk plan then? See Louisiana Workers' Compensation Review, prepared by Independent Insurance Agents of Louisiana.

Brief Summary Text (73):
The situation in Louisiana is not unusual. In many other states, such as Florida and Texas, assigned risk plans in recent years have also operated at a loss.

Brief Summary Text (74):
In addition, workers' compensation has what is known in the industry as a long "tail." That is to say, whereas most different claims in books of insurance business, because of the nature of the product, can be closed after a few years, it takes many more years (some estimate 12-15 years) to close out the average workers' compensation book and claims related thereto. As early workers' compensation insurance carriers began increasing their rates because past claims were rising at an unexpected rate, state legislatures defined more accurately and fully the benefits to be paid to an injured worker in those states. As a result of liberal interpretations under old laws and newer laws that offer greater benefits, workers' compensation rates have risen dramatically.

Brief Summary Text (76):
Self-insurance as a way for funding a workers' compensation obligation is not permitted in the United States in only 3 states (North Dakota, Texas, and Wyoming.) Self-insurance is a provision of law that allows qualifying associations of employers or individual employers, if they have substantial resources, to insure themselves against their workers' compensation and employers liability obligations instead of paying to transfer that risk to an insurance company. Self-insurance can be classified as either group self-insurance or individual self-insurance. The 47 states allowing self-insurance have enacted different laws regulating whether individual and/or group self-insurance is allowed and who may self insure. For example, in Maryland, eligibility for group insurance is limited to counties, municipalities, and certain private employers. In Nebraska, group self-insurance is permitted for any two or more public agencies. (However, the discussion of group self-insurance herein shall be limited to the private sector.) Generally, group self-insurance is regulated by that state's Department of Labor or that state's Industrial Commission.

Brief Summary Text (78):
In those states where group self-insurance is allowed for the private sector, the laws are generally structured to provide for bona fide groups, such as trade associations with a minimum number of members and with a minimum net worth. Because there is a group insuring the risk, the law in some states requires each member be jointly and severally liable for all the risks underwritten by that group. So, for example, in the event that two of five members in a group declare bankruptcy, the remaining three members are liable for all the medical costs, disability costs, and all other workers' compensation costs of those two bankrupt employers' employees. Because such an event could jeopardize the solvency of the remaining three employers, some states require the members to only be liable for their pro rata portion of the risk.

Brief Summary Text (81):
The obvious disadvantages of group self-insurance are: (1) generally, all members of the group are individually liable, or are at least pro rata liable, for all of the group's workers' compensation bills, if the trust is a non profit trust; (2) the group is generally not protected in the event of insolvency by state guaranty funds; (3) many groups either have no employers liability policy or have minimum limits for bodily injury by accidents or disease, with a $500,000-policy limit; and (4) this is not a fully insured plan that is backed by an insurance company which, in turn, is backed by a guarantee fund.

Brief Summary Text (84):
The other way an employer can meet the statutory workers' compensation obligation is by being individually self insured. State laws generally require that the

employer choosing this option post a bond or have a surety guaranteeing the empolyers' net worth. Also, many times the individual must have a large net worth, for example, $500,000. In response to an application to the state by an individual desiring to be self-insured, if the individual has met statutory requirements, the state will allow that individual to be a "Qualified Self Insurer of Workers' Compensation Benefits." Many employers, after having been qualified to become a self insurer, obtain an excess workers' compensation policy with the employer having a large self insured retention.

Brief Summary Text (85):
The disadvantages of individual self insured programs include the following: (1) control of claims remains in the hands of the employer that is not experienced in adjusting and litigating workers' compensation claims; (2) not every employer can meet the requirements to be individually self-insured due to the minimum requirements for the employer's number of employees or financial net worth; (3) employers liability is excluded if no stand alone employers liability policy is purchased, so that there is no coverage to the employer for: (a) damages for which the employer is liable to a third person by reason of a claim against the employer to recover damages against that third party as a result of an injury to an employee of the insured; (b) damages for care and loss of services of an employee of the insured; or (c) damages for consequential bodily injury to a spouse, child, parent, brother, sister of an injured employee of the insured. The employer under individual self-insurance must self insure all of 3-(a), (b), and (c) items, as well as workers' compensation obligation to employees up to a maximum self insured retention. Still another disadvantage of self-insurance is (4) that if the employer becomes insolvent, there is no state guaranty fund to pay the injured employees medical bills, disability, or other compensation due him.

Brief Summary Text (88):
The first type of coverage is known as a "Twenty-four Hour Coverage Marketing Product." This product is marketed by several multi-line insurers that offer "integrated" management of a client's workers' compensation and group health insurance claims. Most state laws preclude combining the benefits available under workers' compensation with those available under other employee benefit plans, so integration is limited to coordinated claims management and/or utilization of the group health discounted provider rates for workers' compensation claims. The policies remain separated and any differences in benefits and coverage between the policies are retained.

Brief Summary Text (93):
There is obvious evidence of a renewal of interest in Twenty-Four Hour Coverage. New interest and activity in 1990 include: 1) The new Florida's workers' compensation law allowing employers to obtain a "Twenty-Four Hour health insurance policy" and a "policy providing indemnity benefits" to satisfy the state's workers' compensation requirements (HB 3809); 2) The California Senate Industrial Relations Committee Report, Healthy Worker-Healthy Workplace: The Productivity Connection, which recommended integrating workers' compensation, disability and group health insurance into a new mandated state-run insurance program. 3) Alaska's recent creation of a Universal Health Care Task Force to consider the option of combining the worker' compensation system with a universal health care program in order to design either a single comprehensive state-wide system or an integrated system of existing health care coverage as delivery systems for a universal health care program (HB 581); 4) Oregon's Legislative Task Force on innovation in Workers' Compensation Insurance, which is to include consideration on the "feasibility of developing mandatory occupational personal injury protection insurance coverage" and coordinating that coverage with "the mandatory provision of health insurance" (SB 1198) along with the Oregon governor-elect calling for combining employees' health insurance coverage with workers' compensation; and 5) Minnesota's report on "Health Care Costs and Cost Containment in Minnesota Workers' Compensation" issued in March by the Department of Labor and Industry which

discussed four Twenty-Four Hour Coverage options, including either mandatory or optional Twenty-Four Hour medical coverage for back disorders only, and Twenty-Four Hour medical and disability coverage for all of an employee's injuries and diseases.

Brief Summary Text (97):
There have been other insurers who have entered and then left this market: (Blue Cross/Blue Shield of South Carolina with Companion Property and Casualty), thereby raising questions about the profitability of this approach. Those companies who have exited the Twenty-Four Hour Coverage cited among others the reasons for withdrawing the product: (1) Marketing Problems--(A) potential clients have a different risk factor to accident and health insurers than they do to workers, compensation insurers, (B) for large employers, workers' compensation is purchased by risk managers or financial officers, while accident and health insurance is purchased by employee benefit or personnel managers, and (C) because of the differences in workers' compensation and accident and health insurance, even multi-line insurers used two different sellers; (2) Administration Problems--include (A) rating differences--workers' compensation rates are heavily regulated, while group health rates are less regulated, (B) premiums for the two products are calculated and paid differently. Group health premiums are generally determined by the number of employees based upon a monthly payroll census and are paid on a monthly basis, but workers' compensation premium rates are often paid quarterly and are based upon payroll classification codes for employees in each industry and/or an employer's loss experience, and (C) health care insurers gather detailed medical information for care management, while workers' compensation carriers gather actual loss information for rate making purposes. Accordingly, there is a lack of comparable historical medical claim information by health carriers needed to control medical costs. Issues in insurance.

Brief Summary Text (98):
Overall roadblocks to Twenty-Four Hour Coverage include: (1) new legislation required authorizing the merger of occupational and non-occupational coverages; (2) the federal Employee Retirement Income Security Act (ERISA) preempts most state regulation of employee benefit plans, such as group health insurance, and preempts even indirect regulation of most benefit plans through state workers' compensation statutes; (3) maintenance of the "exclusive remedy" doctrine worker' compensation laws, which could be threatened by new Twenty-Four Hour Coverage legislation not specifically including it; (4) significant benefit and coverage differences between workers' compensation and other public and private plans (for example, workers' compensation benefits do not have deductibles and co-pay requirements; health insurance policies frequently have richer medical benefit levels than those provided under workers' compensation laws; (5) administrative difficulties imposed by requirements for separate occupational and non-occupational data and operational functions because of federal and state statutory and regulatory requirements, (6) lack of a stand alone employers liability policy sold in conjunction with the Twenty-Four Hour policy (an employer must self insure an employers liability exposure without such a policy); and (7) in those states where workers compensation laws prohibit any employer choice of physician, packages using large volume discount providers (HMO'a, PPO's) cannot be offered for group health and workers compensation medical claims.

Brief Summary Text (101):
A rapidly developing area of the law that enables an employer to satisfy benefits to injured employees for medical disabilities and other occupational injuries is the use of an employee benefit plan authorized under ERISA, the Employee Retirement Income Security Act enacted the federal law in 1974. ERISA not only applies to pension programs, but to other employee benefit plans as well (see 29 U.S.C. .sctn..sctn. 1001-1461). Specifically included within the scope of ERISA are plans providing medical, surgical, and hospital care benefits or benefits in the event of sickness, accident, disability, or death. ERISA was intended to substitute a

federal regulatory scheme for the then existing state regulations and the weak federal statutes then in place.

Brief Summary Text (102):
ERISA specifically preempts "any and all state laws insofar as they may not or hereafter relate to any employee benefit plan" except certain employee benefit plans specifically exempted for the ERISA Act. The most important exemption in the context of this discussion is the one found in 29 U.S.C. .sctn. 1003(b)(3) for plans "maintained solely for the purpose of complying with applicable workers' compensation laws or unemployment compensation laws or disability insurance laws" (emphasis added).

Brief Summary Text (103):
On May 18, 1981, the Supreme Court unanimously affirmed the decision of the Third Circuit in Buczynski v. General Motors Corp., 616 F.2d 1238 (1980) sub mon Alessi v. Ray Bestos Manhattan, Inc., 451 U.S. 504, May 18, 1981. In so doing, the court resolved the issue of the right of employers to integrate pension plan benefits with state workers' compensation benefits by reducing the one by the other. The Supreme Court made it clear that qualified plan benefits may be offset by workers' compensation benefits and that state law to the contrary is preempted by ERISA. Absent congressional action, there is no longer any questions that workers' compensation integration is lawful under ERISA. Since Alessi other court cases have aided in the interpretation of Alessi in this expanding area of the law, for example: Shaw v. Delta Air Lines. Inc., 463 U.S. 85, 77 L. Ed. 2d 490.103 S. Ct. 2890 (1983); see also Gibbs v. Service Lloyds Insurance Co. 711 F. Supp. 874 (E.D. Texas, 1989); Foust v. City, Ins. Company, 704 F. Supp. 752 (W.D. Texas, 1989); Stone and Webster Engineering v. Ilsley, 690 F.2d 323 (2d Cir. 1982), aff'd, 463 U.S. 1220 (1983); and Fixx v. United Mine Workers', District 17, 645 F. Supp. 352 (S.D. W.Va. 1986).

Brief Summary Text (105):
Legal efforts to avoid the ERISA preemption and to avoid removal to federal court are often centered on arguments that negligence or pain and suffering are not contemplated by the employee benefit plan. To that argument the Supreme Court recently explained: "[a] Saw `relates to` an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan . . . Under this "broad common sense meaning," a state law may "relate to " a benefit plan, and thereby be preempted even if the law is not specifically designed to affect such plans, or the effect is only indirect.

Brief Summary Text (107):
If federal law preempts the state law, the plaintiff's lose state court remedies such as penalties, unfair trade practices remedies, attorney's fees, and other state court remedies.

Brief Summary Text (108):
All of this having been said, there are obvious setbacks to maintaining that ERISA is a broad scale answer to the workers' compensation dilemma in the United States. The current disadvantages of this use of ERISA are set forth below.

Brief Summary Text (109):
(1) Local--Because ERISA is a relatively new statute with few cases interpreting the statute, the law as to how to use ERISA to fund the workers' compensation obligation is unclear in many areas. Additionally, an ERISA plan under 29 U.S.C. .sctn. 1003(b)(3) not maintained solely for the purpose of complying with workers' compensation law would be subject to ERISA and state law would be preempted.

Brief Summary Text (116):
By severing a standard workers' compensation policy into two parts, many price benefits can be obtained. For example, because a life, accident, and health

insurance company would not be considered a workers' compensation insurer and a member of the NCCI, the carrier would not be forced to participate in assignments from the state assigned risk pools; nor would it be forced to assessments by the state plans administered by the NCCI. A property and casualty carrier who is not a member, purchaser, or subscriber of the NCCI and whose charter does not allow it to write workers' compensation insurance in some states, can be used to insure one part of this plan. These savings by the insurance carriers can be passed on to the employer consumer in a reduction of the price of the combination of the two insurance products.

Brief Summary Text (117):
Additionally, in certain states, when the employer is in the assigned risk pool, many times there is a surcharge based upon a percentage of premium added to the price of the standard workers' compensation premium. By taking that employer out of the assigned risk pool, that employer faces no surcharge, thus decreasing again the workers' compensation insurance cost. Depopulating the assigned risk pool is a goal of most commissioners and insurance regulators, and an object of the present invention is to help accomplish that goal.

Brief Summary Text (118):
Presently, it appears that using this combination of policies may be permissible in 15 states. These states appear to be Alabama, Connecticut, Florida, Georgia, Illinois, Iowa, Missouri, Oklahoma, Rhode Island, South Dakota, Utah, West Virginia, Louisiana, Minnesota, and Wisconsin. Two others, Michigan and Oregon, permit the use of equivalent benefits by certain limited categories of employer. But, each of the states needs to be analyzed on a case-by-case basis with regard to whether its insurance denartment's interpretation of the workers' compensation law permits equivalents.

Brief Summary Text (119):
It is important to note that the states mentioned in the preceding paragraph do not require the insurance company issuing the workers' compensation benefits to have its license specifically authorize the company to write workers' compensation insurance. That is, a life, accident, and health carrier does not need to amend its charter to sell health insurance that constitutes the equivalent to the workers' compensation benefits coverage.

Brief Summary Text (120):
In order to insure that there are no gaps in coverage arising from the separation of the workers' compensation exposure from the employers liability exposure, the policies are issued simultaneously to an employer. Additionally, the part A policy has a difference in coverage/condition ("DIC") wording which, in essence, provides that if there are any differences between the terms and conditions of the policy and that which would be paid under that state's workers' compensation statute then the policy is to provide that coverage. Additionally, the part A policy has a "conformity to a standard workers' compensation policy" clause, which provides that if the terms and conditions of this policy would be different than that provided by a standard workers' compensation policy, then the policy is amended to provide for the same coverage, minimum terms, and conditions of that standard workers' compensation policy. To protect the carriers, if one of the policies is cancelled or lapsed, then the other is cancelled. According to each state's interpretation, the part B coverage can have a conformity to a standard employers liability policy clause which provides that if the terms and conditions of this policy would be different than that provided by the standard workers' compensation with the employers liability insurance contained therein) then this policy is amended to provide for the same coverage minimum terms and conditions of that standard employers liability coverage contained in the standard workers' compensation policy.

Brief Summary Text (121):

As noted earlier, Part A of a standard workers' compensation policy does not outline the benefits it will pay under that state law. Under the financial product associated with the present invention, all of the benefits of a particular state's workers' compensation law are preferably put into the terms and conditions of the policy, including medical, disability, death, burial, and other statutory benefits.

Brief Summary Text (127):
Yet another advantage of the underlying financial product of the present invention is that it is a fully insured plan. In those states where this plan will be admitted not under an assessable mutual plan or a group self-insurance plan, the employer will have first dollar coverage by A. M. Best-rated carriers.

Brief Summary Text (128):
Employers liability insurance is an essential and indispensable protection required by employers. It covers the cost of legal defense and provides coverage against intentional injury claims, dual capacity claims, and third party over claims. While the majority of states still hold that workers' compensation benefits are the exclusive remedy an injured employee has against his employer, employers liability coverage is required to insure in the above-mentioned situations. Employers liability being a part of the combined financial product gives an advantage in marketing over most individual and group self insured plans, Twenty-Four Hour Coverage plans, and ERISA trust plans. The employers liability policy is issued on a separate basis, where it can be sold either on an admitted basis or on a surplus lines basis, according to that state's law. If sold on an admitted basis, that state's guarantee fund for that liability policy is provided. If sold on a surplus lines basis, no guarantee fund protection is available. However, this is mitigated by using quality (B+-rated or better) carriers, and by taking into consideration employers liability claims are few and far between.

Brief Summary Text (129):
Pricing, being one of the most important factors in any marketing plan, is a major advantage of the financial product underlying the present invention. In those states which are not monopolistic and in which the NCCI suggests adequate rates for workers' compensation and which have assigned risk pool assessments or assignments or surcharges for employers in the assigned risk pool, this financial innovation may save an employer up to twenty (20%) percent of the premium compared to a standard workers' compensation policy, yet there still is full statutory coverage with quality carriers. In those states which allow the use of HMO's or PPO's, the savings may be greater.

Brief Summary Text (130):
Further, with regard to the understanding that the employer is in all plans the ultimate responsible party to provide workers' compensation benefits to injured employees in the "compulsory states," the severing of Part A and Part B to a standard workers' compensation policy gives the least exposure to the employer. Under state law, the insurance company is liable to the injured employee. If the insurance company should fail, then the state guarantee fund becomes liable. Then, if the guarantee fund should not pay, the employer must do so. Contrast this with group self-insurance or assessable mutuals, where first the premium pool pays, and, if it becomes insolvent, then all member employers are jointly and severally liable or pro rata liable for all other members' workers' compensation obligation to its injured employees (in those majority of states that do not have guarantee funds or group insurance). In individual self-insurance, the individual employer already pays first dollar up to a retention limit, then the excess insurance begins to pay. In ERISA plans, depending on the structure of the plan, and in Twenty-Four Hour Coverage plans, depending on the states various laws, it is difficult to legally determine if guaranty funds would have to legally be obligated to pay in the event of insolvency of participating insurance carriers.

Brief Summary Text (131):
With regard to the reporting of the statistical data on losses and rates, the states allowing the financial product underlying this invention may instruct a carrier or its designee to report to either the state workers' compensation board, the department of insurance, or the NCCI to track the experience modification (loss history) sustained by each individual employer.

Detailed Description Text (29):
The second question is "Does the employer have first-aid on the premises? Y/N." If N is entered a warning screen will appear to state that if there is no first-aid on the premises, a 25% surcharge will be added to the totals column. If Y is entered, 0.00 will appear in the totals column.

Detailed Description Text (74):
Rate values per $100 of payroll are stored in the Rate Book database, and there would be a separate set of rates for each state. One set of rates is provided as an appendix hereto. Another set of rates is on file with the Insurance Commissioner of the state of Alabama. The general formula for computing a premium involves multiplying the rates times the respective payrolls for the given rates and these are then summed to produce the premium (plus or minus some adjustments detailed later herein).

Detailed Description Text (83):
Other information is filled out depending on the facts of the case. Of particular interest is the prior history of the employer. This information includes, for example, the name of the insurer, annual premium paid, any modification (an adjustment reflecting whether the employer is a good insurance risk, e.g., 0.91), number of claims in a year (e.g., 13), the amount of losses paid (e.g., $2,690.00) and the reserves, if any (e.g., 0.00). Insurance histories for particular employers are useful in estimating future risk.

Detailed Description Text (85):
To more particularly describe the manner of determining rates so that the premiums can be computed according to the present invention, it should be noted that this invention uses rates different from those used in the prior art. First, (with comparison to, say, NCCI rates) the total rates of the present invention are discounted for part A and part B to reflect the fact that there is no assessment for the unbundled policies. By severing the standard workers' compensation policy into the two policies, neither of the two policies is in the assigned risk pool. Thus, there is no assessment, which is reflected in the lower total rates for the part A and part B policies. Second, in some states, on top of the assessment given to the insurance companies, the insured employer must pay, if in the assigned risk pool, a surcharge. However, the total rates for the separate part A and part B policies in these states have rates that do not have a surcharge. This is because an unbundled set of policies is not in the assigned risk pool. Third, the part A rate is tailored against the part B rate to reflect different statutory risk exposures in different states. For example, in one state, part B may have to be greater than it would be in another state. Nonetheless, the total for the rates for the part A policy and the part B policy of the present invention is less than the singular NCCI rates for the same classifications by sometimes as much as 20%, or more commonly, in the range of 10% to 15%. In any case, the total rates are less than that of the standard workers' compensation rate for the same classification.

Other Reference Publication (12):
Adler, Stacy; Risk Management Honor Roll; Business Insurance; Apr. 29, 1991; p. 161; Dialog # 03121054.*

CLAIMS:

1. A digital electrical computer system controlled by a program to compute one

premium for the workers' compensation benefit coverage and a separate premium for the employers liability coverage, the system comprising: a digital electrical computer controlled by a computer program in processing input electrical signals, the input electrical signals being produced in response to data entered at a data input device that is electrically connected to the digital electrical computer, the digital electrical computer also being electrically connected to an output device; a memory, electrically connected to the digital electrical computer, storing a set of rates for at least part of workers' compensation benefit coverage and storing a second set of rates for at least part of employers liability coverage, both said rates corresponding to categories of work that can be done by employees under both of said coverages, both said coverages collectively satisfying all coverage requirements for workers' compensation in at least one state; and wherein said a digital electrical computer controlled by said computer program controls computing the one premium for the workers' compensation benefit coverage and the separate premium for the employers liability converge in response to at least one of said rates from both said sets of rates stored in said memory and to the data entered at said data input device, said data including an amount of payroll paid to the employees for work in at least one of the categories of work; and wherein the modified electrical signals produce a depiction of the premiums of the output device.

2. The system of claim 1, wherein said memory stores separate sets said sets of said rates for each of a plurality of states.

4. The system of claim 3, wherein said memory stores one set of both said rates for each of a plurality of states for selectably computing said premiums for a respective state.

6. A process for using a machine to use data entered for a first insurance policy in processing for a second insurance policy that collectively satisfy all statutory coverage requirements for worker's compensation in at least one state without paying either a nongovernmental charge for an assessment or a nongovernmental charge for an assignment, the process comprising: using a digital electrical computer system, including a processor electrically connected to memory, to input means, and to output means, programmed to receive multiple related insurance policy data at said input means, to store said multiple related insurance policy data in said memory, to process said multiple related insurance policy data into a predefined format, and to generate output data at said output means; wherein said multiple related insurance policy data includes insurance policy-identifying data representing a first insurance policy and a second insurance policy, the insurance policies selected, sold together in sets, and related to collectively satisfy all statutory coverage requirements for worker's compensation in at least one state without paying either a nongovernmental charge for an assessment or a nongovernmental charge for an assignment; and wherein said output data includes at least a portion of said multiple related insurance policy data presented in said predefined format.

14. The process of claim 7, further comprising the step of controlling the digital electrical computer system with said logic means to receive agent-identifying data for both of the insurance policies in one of the states, the agent-identifying data including the identity of an agent for both said insurance policies.

17. A process using a computerized data processing system programmed to use data to produce a customized application form for at least a portion of multiple insurance policy worker's compensation coverage, the process comprising the steps of: storing in an electrical data processing system comprised of a digital electrical computer connected to electrically communicate with a key board, a memory, and a printer, a template and a respective application form for a first insurance policy for use in combination with at least a second insurance policy, said insurance policies collectively satisfying all statutory coverage requirements for workers'

compensation in at least one state without paying a nongovernmental assessment or a nongovernmental assignment; controlling said digital electrical computer with a program to receive data input at said key board to insert said data into the first template to produce a first customized application form for said first policy.

23. A process for using a machine to use data entered for a first insurance policy in processing for a second insurance policy that collectively satisfy all statutory coverage requirements for worker's compensation in at least one state without paying a National Council on Compensation Insurance charge, the process comprising: in an digital computer system including a digital electrical computer electrically connected to memory, to input means, and to output means, controlling the system, with a program to perform the step of generating a first premium as output at said output means, wherein the generating includes computing the first premium from a first set of rates entered at the input means, the rates being those for a first insurance policy and to perform the step of generating a second premium as output at said output means, wherein the generating includes computing the second premium from a second set of rates entered at the input means, the rates being those for a second insurance policy; wherein said first insurance policy and said second insurance policy are selected for use in combination such that the insurance policies collectively provide a coverage satisfying all statutory requirements for workers' compensation in at least one state; and wherein at least one of said premiums does not include a National Council on Compensation Insurance charge.

24. The process of claim 23, wherein the steps of controlling the computer system with logic means are carried out such that a total formed from addition of the premium computed for the first insurance policy plus the premium computed for the second insurance policy is less than an amount corresponding to a premium for the coverage by a standard workers' compensation policy approved in the same state as the first insurance policy and the second insurance policy, the total being less than the amount due to an absence of a computing step in which the National Council on Compensation Insurance charge is added in forming the total.

25. A process for using a machine to use data entered for a first insurance policy in processing for a second insurance policy that collectively satisfy all statutory coverage requirements for worker's compensation in at least one state without computing either a private assessment charge or a private assignment charge, the method comprising: controlling a digital electrical computer system including a processor electrically connected to memory, to input means, and to output means, with a program to perform the step of generating a first premium as output at said output means, wherein the step of generating includes computing a first premium from a first set of rates for said first insurance policy combined with at least a second insurance policy to collectively satisfy statutory coverage requirements for workers' compensation in at least one state, and wherein the generating is carried out without computing either a private assessment charge or a private assignment charge.

36. A process for making an electrical digital computer system programmed to generate output including a premium for a first insurance policy and a premium for a second insurance policy for combined coverage that collectively satisfies all statutory coverage requirements for workers' compensation in at least one state without paying either a nongovernmental charge for an assessment or a nongovernmental charge for an assignment, the process comprising the steps of: providing a processor electrically connected to a memory, to input means, and to output means in forming a digital electrical computer system; programming said processor for controlling the digital computer system to receive multiple related insurance policy data at said input means, to store said multiple related insurance policy data in said memory, to determine from said multiple related insurance policy data a premium for the first insurance policy and a premium for the second insurance policy for collective coverage that satisfies all statutory coverage requirements for workers' compensation in at least one state without paying either

a nongovernmental charge for an assessment or a nongovernmental charge for an assignment, and to generate output data including said premiums at said output means.

Previous Doc Next Doc Go to Doc#

L4: Entry 3 of 3 File: USPT Dec 30, 1997

DOCUMENT-IDENTIFIER: US 5704045 A
**** See image for Certificate of Correction ****
TITLE: System and method of risk transfer and risk diversification including means to assure with assurance of timely payment and segregation of the interests of capital

Brief Summary Text (7):
These structures operate on the basis of transferring risk to an entity which utilizes one of two primary forms of capital structure: a capital leveraging system (banks and insurance companies) or a capital matching system (the exchanges and markets).

Brief Summary Text (8):
Under the capital leveraging system, an insurer may accept any type or amount of risk, subject to internal underwriting guidelines and regulatory restrictions. This format provides a significant degree of flexibility in the pricing, terms, and limits of risks accepted. These insurers operate on the premise that premiums cover claims. Their capital is available to pay claims if losses exceed premiums and investment income. The aggregate of policy liabilities though, is generally much larger than their combined premium and capital. So, like a bank which couldn't pay if all depositors asked for their money, insurance companies are not generally designed to pay if all policies claimed their limits.

Brief Summary Text (9):
Leveraging capital, i.e., a small amount of capital compared to the risk exposures assumed, translates a small underwriting profit on premium into a substantial return on capital. Conversely, a relatively small loss over premium results in a significant loss to capital. This system does not absolutely assure an insurer's ability to pay in that an insurer's policy limits are generally much larger than its assets. Hence an insurer must only accept risks common to many people, limiting its exposure to each single risk to a small percentage of its capital, and relying on geographic and risk type diversification, as well as reinsurance, to protect its shareholder's capital. This works well when losses are predictable. It's when insurers accept unique or difficult-to-place risks that premium as well as capital may not be sufficient to cover claims. Even, Lloyd's of London (which operates in a manner similar to a collection of small insurance companies with the exception that should losses exceed available funds, its underwriting members, similar to shareholders, can be forced, in theory, to pay up to the limit of their assets) has experienced such difficulties.

Brief Summary Text (13):
Each system operates on the basis of accepting risks which are common to large numbers of people. As financial transactions and our world in general grow more complex, certain types of risk exposures have become increasingly difficult to transfer in today's markets. In the insurance markets, catastrophic events and judicial reinterpretation have caused a contraction in some types of insurance capacity. It appears that today's insurance markets are frequently unable or unwilling to facilitate the transfer of unique risks such as those with a high

possibility of loss, where the loss could come earlier rather than later or with more severity than projected. The exchanges have taken some steps toward addressing unique risks, such as catastrophe futures contracts, but again the terms are restrictive and do not easily integrate with the flexibility of a reinsurance contract. In essence, the exchanges nor mutual funds can accept a single unique risk.

Brief Summary Text (14):
In an efficient marketplace, effective risk management decisions might simply be a matter of a cost/benefit analysis. In practice, such decisions are often driven by the availability and pricing of risk transfer alternatives as well as by regulatory and accounting considerations. Unable to reduce certain types of significant exposures or to find adequate risk transfer alternatives, companies are often faced with a decision to retain exposure to certain risks or transfer only a portion of such risks to existing markets. For these exposures, today's financial and insurance markets often do not provide adequate risk transfer alternatives, the price may be so substantial as to warrant retention, or the ability of the transferee to perform in the event a loss materializes may itself be a concern.

Brief Summary Text (19):
The present invention brings together using a data processing system novel financial management links in a preferably statutorily protected structure which improves upon the underwriting flexibility of an insurance company, risk taking activities of other enterprises, and other attributes of capital leveraging structures with risk and capital matching principles similar to those employed by major international exchanges and mutual funds, in an absolutely secure environment. It permits an entity adopting the system to marshal adequate funds provided by various classes of investors to accept risks not efficiently transferable in existing markets while providing assurance that all claims will be paid from its segregated assets. This arrangement provides a comparatively higher quality assurance of risk transfer. Further, each investor's liability is limited to its investment.

Brief Summary Text (20):
The primary components of the system, in addition to establishing the system on a new or existing business enterprise, are i) the participation of external market specialists; ii) a method of external regulation and fiduciary oversight; and iii) the risk acceptance, risk diversification and reserve management subsystems.

Brief Summary Text (24):
This subsystem relies on the expertise of third party specialists using the data processing system to agree the acceptance of risk. As each risk is accepted, a contract is issued defining specific terms and transactional capital (under the care of independent custodians and sufficient to pay the maximum limit on the contract) is allocated through use of the data processing system to a statutory reserve account to support the agreement being issued. To further protect the interests of contractholders, a "statutory charge", "mortgage", or "security interest" is placed on the assets supporting the contract and is filed with appropriate government regulators.

Detailed Description Text (21):
Regulatory/Fiduciary Interaction

Detailed Description Text (45):
The method and system of the present invention is not limited to acceptance of risks common to many people nor does it impose the rigid contract limitations of an exchange-based structure. Risks accepted by the insurer-entity could include credit and liquidity risks on corporate and municipal government debt and lease obligations which are unrated or non-investment grade, thereby substantially increasing their liquidity and market value. The insurer-entity is also capable of

indemnifying insureds for loss on a change in value of marketable shares, agricultural products, precious metals, petroleum, fluctuations in interest or currency rates, or residual value. It could issue ICC #458 demand guarantees, similar to a letter of credit issued by a bank, or other performance or surety risk contracts; or accept any type of traditional insurance risk, as well as unique or difficult to place risks, such as catastrophe, excess or aggregate exposures, liability or contract risks, or unfunded potential exposures (pollution liability, etc.).

Detailed Description Text (50):
An underwriter may be a firm of professionals contracted for a particular type of expertise, a traditional insurance company in which the insurer-entity reinsures risks underwritten by the insurer's underwriting staff, a bank or other risk management professional who is experienced in risk analysis, acting in a manner similar to a market specialist on a major exchange.

Detailed Description Text (59):
Each segregated reserve is a separate account or ledger established by the insurer-entity to allocate the interests of policyholders, capital participants, professionals and for other purposes, which permit the insurer-entity, fiduciaries and regulators to ascertain that the insurer-entity can at all times satisfy its obligations to all parties. These may take the form of policy reserves, capital reserves, and administrative reserves. Monies held by custodians are allocated across these reserves, being tracked electronically by the data processing system.

Detailed Description Text (74):
b) the investors, lenders, reinsurers, or other risk takers who use these structures--General Assets may be transferred to Reserved Assets or third parties can deal directly with the insurer-entity through its Reserved Assets substructure, without going through the General Assets substructure. The initial difference in the two substructures is the security aspects afforded Reserved Assets. By statutory means, the priority of claims upon assets is altered. The insurer-entity can subdivide Reserved Assets into any number of accounts for tracking the insurer-entity's obligations to various parties including to its General Assets substructure, providing ease of regulatory inspection and reporting. The insurer-entity upon creation of an account within its books of account prepares a document setting out the uses and purposes of the account; records the quantum of funds allocated to the account, the maximum period such funds may remain allocated thereto, any compounding rate at which additional funds might be credited to the account, and types of investment risk to which such funds could be subjected; the type of risks and/or parties for whose risks such funds could be supportive; the terms under which funds could be reallocated to other reserve accounts, for allocations representing professional fees, administrative fees, returns of collateral, reductions for transfers to participants hereafter referred to as "transactional capital participants", and transfers to General Assets (FIG. 6). Upon the issuance of a policy, the insurer-entity takes the additional step of placing a "security interest", filed with government, on a portion of the insurer-entity's Reserved Assets, which has the effect of blocking the reduction of any funds allocated to a reserve account, except for payment of claims or contractually obligated payments, until a reduction of liability is properly certified. Reserved Assets are thus subject to specified use, protected from the claims of general creditors in the event of a liquidation or bankruptcy of the insurer-entity, and may only be used as per the instructions attached to each reserve account.

Detailed Description Text (104):
To achieve a similar objective, the prior art would only permit the materials supplier to invest in the shares of an insurance company established specifically to accept property catastrophe risks or to buy lumber or property catastrophe futures contracts. The latter may involve a substantial amount of volatility, requires a thorough knowledge of the risks of taking futures positions and is not

as appropriately matched for natural hedging purposes. The costs can also be somewhat prohibitive. Investing in the publicly traded shares of a property catastrophe insurer does provide another option, however the volatility of price and direction of movement may not coincide with the geographic distribution of risks to which the materials supplier would normally profit. For instance, large losses resulting from a catastrophic event insured in another country could precipitate a decline in the value of the publicly traded shares of the property catastrophe insurer, with no corresponding building materials sales benefits. The supplier would also be subject to decline in the price of shares, in those years in which an oversupply of insurance capacity existed, as often occurs in the cyclical property insurance markets.

Detailed Description Text (105):
The present system provides for a means of permitting the supplier to indirectly participate in the property catastrophe market when insurance capacity is limited and premiums are high, and be out of the market when rates are low and capacity in abundance. This is accomplished by the supplier's selecting an investment manager to annually allocate the supplier's transactional capital funds transferred to the insurer-entity, based on prescribed guidelines. For instance, the reserve agreement require the $100 million be invested in short-term government securities while supporting insurance risks. During those periods where the investment manager elects not to support insurance risks due to low premium levels, a variety of alternate investments might be permitted, thus maximizing potential returns on the supplier's transactional capital.

CLAIMS:

2. The method in accordance with claim 1, further comprising creating risk transfer policy/contracts having policy limits identified to specific accounts,

transferring and matching all or a portion of the risk to one or more investors under a capital structure which includes ready means of payment to parties transferring risk, if losses materialize, and segregation of the interests of particular investors to specifically identified risks;

utilizing computer-based storage, processing and retrieval communication and recording means for coordinating the creation of such risk transfer policy/contracts and the capital including segregated interests to provide at all times monies to satisfy the full policy limits of all contracts;

establishing, implementing and administering the system through use of said communication and recording means as a part of a new or existing entity, which includes a capital structure protected by law; and

employing said means to effect existing external regulation and fiduciary oversight to assure satisfaction of all contracts, to protect the structure, entity, and parties transferring risk and capital providers from risks of insolvency, judicial intervention by third parties, and other external entity risks.

10. The method in accordance with claim 1 further comprising:

creating through computer-based data processing means risk transfer contracts which are identified to specific accounts, then transferring and matching all or a portion of the risk to one or more capital providers under a capital structure; which includes ready means of payment to parties transferring risk, if losses materialize, and segregation of the interests of particular capital providers;

utilizing a computer-based data storage, processing and retrieval means for coordination the creation of such risk transfer contracts, and the capital structure including segregated interests to provide at all times monies to satisfy

the full limits of all contracts;

operating said computer-based means for establishing, implementing and administering the system as part of a new or existing entity which includes a capital structure protected by law;

employing said computer-based means to effect existing external regulation and fiduciary oversight to assure satisfaction of all contracts, to protect the structure, entity, and parties transferring risk and capital providers from risks of insolvency, judicial intervention by third parties, and other external entity risks.

34. The system of claim 32 having in addition:

a means of inputting the underwriting committee's risk acceptance authorization code for the particular risk in the automated issuance system; and

a means of inputting the amount of funds received and a wire transfer code from the custodian confirming receipt of compensation for acceptance of the risk;

means for inputting for ready retrieval created segregated reserves within the accounts of the entity accepting the risk, separate accounts for contract holders, capital participants, entity consultants, and for other purposes, which further permit the entity, fiduciaries regulatory parties to ascertain the entity's obligations and its ability to fully and completely satisfy such obligations on a timely basis; and

a means for inputting for ready retrieval to allocate the compensation received among the various reserve accounts to assure the entity's ability to fully and completely satisfy the terms of the contract and to provide for administrative and professional fees associated with acceptance of the risk.

Previous Doc Next Doc Go to Doc#

L2: Entry 1 of 1 File: USPT Sep 12, 2000

DOCUMENT-IDENTIFIER: US 6119093 A
TITLE: System for syndication of insurance

CLAIMS:

16. A computer readable medium in which is stored computer readable code to be executed by a computer, the computer readable code performing a method of syndicating underwriting of an insurance policy, the method comprising the steps of:

receiving policy information regarding the insurance policy;

storing the policy information on a data storage device;

transmitting an invitation for electronic viewing by a potential buyer to offer to buy a share in an underwriting of the insurance policy, the invitation including at least a portion of the policy information, the share having associated therewith a risk cost assessable to a buyer if a payment to an insured is made pursuant to the insurance policy;

receiving an offer to buy the share, the offer including information identifying a buyer and collateral against which the risk cost may be charged if the payment to the insured pursuant to the insurance policy is made, the collateral being a line of credit on a credit account;

storing data on the data storage device that associates the policy information and the buyer;

initiating a communication to determine an availability of credit sufficient to cover the risk cost;

requesting a credit freeze with respect to the credit account so as to secure a credit amount necessary to cover the risk cost; and

transmitting to the buyer an indication of acceptance of the offer and the collateral.

17. A system for facilitating a syndicated sale of an insurance policy, comprising:

a first processing system including

a first processor,

a first communication device connected to the first processor for performing Internet communications, and

a first storage device connected to the first processor, the first storage device

containing a first program, adapted to be executed by the first processor, for

receiving on the Internet policy information regarding the insurance policy, transmitting on the Internet an invitation for electronic viewing by a potential buyer to offer to buy a share in an underwriting of the insurance policy, the invitation including at least a portion of the policy information, the share having associated therewith a risk cost assessable to a buyer if a payment to an insured is made pursuant to the insurance policy,

receiving on the Internet an offer to buy the share, the offer including information identifying collateral against which the risk cost may be charged if the payment to the insured pursuant to the insurance policy is made, the collateral being a line of credit on a credit account,

initiating a communication to determine an availability of credit sufficient to cover the risk cost,

requesting a credit freeze with respect to the credit account so as to secure a credit amount necessary to cover the risk cost, and

transmitting on the Internet to the buyer an indication of acceptance of the offer and the collateral;

a second processing system including

a second processor,

a second communication device connected to the second processor for performing Internet communications, and

a second storage device connected to the second processor, the second storage device containing a second program, adapted to be executed by the second processor, for

providing the policy information on the Internet,

initiating payment of a portion of a premium associated with the insurance policy to the buyer, the portion having a size in accordance with the share, and

initiating a communication to make a charge against the credit account in accordance with the share if the payment to the insured pursuant to the insurance policy is made; and

a third processing system including

a third processor,

a third communication device connected to the third processor for performing communications, and

a third storage device connected to the third processor, the third storage device containing a third program, adapted to be executed by the third processor, for

responding to the communication from said first processing system to determine the availability of credit sufficient to cover the risk cost,

performing the credit freeze with respect to the credit account,

transmitting to said first processing system a verification of the credit freeze, and

making the charge against the credit account in response to the communication from said second processing system.

18. A method of syndicating underwriting of an insurance policy by using Internet communications, the method comprising the steps of:

providing policy information on the Internet regarding the insurance policy;

transmitting on the Internet an invitation for electronic viewing by a potential buyer to offer to buy a share in an underwriting of the insurance policy, the invitation including at least a portion of the policy information, the share having associated therewith a risk cost assessable to a buyer if a payment to an insured is made pursuant to the insurance policy;

receiving on the Internet an offer to buy the share, the offer including information identifying collateral against which the risk cost may be charged if the payment to the insured pursuant to the insurance policy is made, the collateral being a line of credit on a credit account;

determining an availability of credit sufficient to cover the risk cost;

initiating a credit freeze with respect to the credit account so as to secure a credit amount necessary to cover the risk cost; and

transmitting on the Internet to the buyer an indication of acceptance of the offer and the collateral;

initiating payment of a portion of a premium associated with the insurance policy to the buyer, the portion having a size in accordance with the share; and

charging against the credit card account in accordance with the share if a claim payment to an insured pursuant to the insurance policy is made.

Previous Doc Next Doc Go to Doc#

L4: Entry 1 of 3 File: PGPB Mar 21, 2002

DOCUMENT-IDENTIFIER: US 20020035488 A1
TITLE: System and method of administering, tracking and managing of claims processing

Pre-Grant Publication (PGPub) Document Number:
20020035488

Summary of Invention Paragraph:
[0005] Processing, tracking and releasing funds for claims made upon insurance policies and similar risk shifting mechanisms has traditionally been a time intensive and resource intensive process. Traditionally, there are six major steps involved in the processing of claims: initial claims processing, loss appraisal, claims adjusting, satisfying the claim, settlement and payment, and management and analysis.

Summary of Invention Paragraph:
[0015] As each of these processes presents difficulties, complexities to systems and processes which seek to address them, the combination of these processes, each of which needs to be addressed in claims processing, provides even deeper inefficiencies that have yet to be adequately addressed. Traditional claim management systems are each focused on a single or a few of these steps involved in processing claims, and often require the redundant re-collection, re-entry or reformatting of collected information and data to cater to the specific needs of each of the processes involved. For a paper based claim file management system, information is limited to the number of physical copies of the material available, which are static and costly to move and store. In addition, bottlenecks are created when files are kept, for example by a claims adjuster who cannot be reached. For electronic claim management systems, proprietary systems, formats and communication methods similarly require redundant effort in the need to re-enter or reformat data to cater to each system involved in the process. Traditionally, there does not exist a centralized claim processing or storage system. Traditionally, claims processing is people intensive, requiring human involvement for phone calls, data collection and data entry, often requiring several days, and considerable inconvenience to the client while adding significantly to the insurance carrier's costs of adjusting the losses under claims.

Summary of Invention Paragraph:
[0017] The present invention provides a centralized system and methods of administering, tracking and managing claims processing. More particularly, the system and method processes, tracks and releases funds for claims made upon insurance policies and similar risk shifting mechanisms including but not limited to self insurance, indemnity provisions and surety and performance bonds. The invention is composed of sub-systems that can operate on a standalone basis or in conjunction with one or more sub-systems of the invention. The sub-systems include:

Brief Description of Drawings Paragraph:
[0064] FIG. 29 is a screenshot of a report generated by a reporting sub-system that is indexed by region and by the states within each region;

Detail Description Paragraph:
[0067] The present invention provides system and methods of administering, tracking and managing claims processing. More particularly, the system and method processes, tracks and releases funds for claims made upon insurance policies and similar risk shifting mechanisms including but not limited to self insurance, indemnity provisions and surety and performance bonds.

Detail Description Paragraph:
[0135] FNOL 210 can be implemented to allow an user, for example, a consumer, i.e., any individual who is not a policyholder and is not acting on behalf of a commercial participant (e.g., a claimant claiming damages under an insurance policy caused by a policy holder), a policy holder, i.e., any individual who has a policy with the insurance carrier involved, and a commercial participant, i.e., a party acting on behalf of the insurance carrier involved (e.g., a call center representative, an insurance agent, or an insurance adjuster) to input initial loss information over a web based channel. In one embodiment, the web-based channel is available 24 hours a day.

Detail Description Paragraph:
[0137] Referring to FIG. 5A, a flow diagram of the process of capturing initial claim data, in step 502, the user initiates the claims process using an I/O device 1. In one embodiment, the process is initiated via an insurance carrier's system 65. In another, the user connects to the insurance carrier's website and begins to file a claim of loss based on insurance carrier rules. Next, the consumer selects 504 to submit a new claim loss, which interfaces the user to FNOL. FNOL 210 can be branded for that insurance carrier. In another embodiment, a user can directly connect to FNOL 210 in the application layer 213 and initiate the process of capturing initial claim data.

Detail Description Paragraph:
[0140] If the policy is not valid (e.g., there is no record of the insurance policy being asserted or the date of the loss is outside of the policy coverage period), an error message will be returned to the user and the user will be given additional opportunities to enter valid policy information. For example, the policy information may have been entered incorrectly and no matching policy exists. If valid policy information is still not entered after a set number of attempts, e.g., 5, the user will be informed that an error has occurred, that the user should contact the insurance carrier, and will be given 510 the insurance carrier's contact information. FNOL 210 also determines if the policy information entered violates insurance carrier business rules and automatically implements actions stored to handle such violation (e.g., if the date of loss is outside of the policy period, then FNOL 210 communicates to the user that the user should contact the insurance carrier and provides the insurance carrier's contact information). In one embodiment, after the claim is initiated the consumer is asked to identify what type of loss they wish to report (e.g., automobile, life, renters, health, and homeowners). This information will help to funnel off claims that are not be appropriate to report through FNOL 210 and may help with the triage sub-system 220 and assignment sub-system 230 described more fully below.

Detail Description Paragraph:
[0161] For example, if the user selects moderate front end damage to a vehicle, FNOL 210 would alter a graphic of a vehicle to represent moderate front end damage. Subsequently, if the user did not find the graphical representation to be accurate, he could change alter his selection of damage location and degree and would be presented with a new depiction of his selection. When the user finds the depiction to be accurate, the graphical depiction is stored along with other claim data. For example, FIG. 8 is an interactive user interface to varying the degree of damage to a representative vehicle graphic. The vehicle graphic starts in an undamaged state, but changes as and according to the user's input as to the location and degree of damage. Each user submission of location and degree of damage changes the graphic,

until the user is satisfied with the depiction and submits the depiction.

Detail Description Paragraph:
[0179] Loss location (state, city, zip & county)

Detail Description Paragraph:
[0199] Regulatory conditions

Detail Description Paragraph:
[0217] Using these examples, the separate score of either of the two examples listed above could easily be low, indicating that these claims might qualify for automated adjusting by directing the claim to a repair facility and then automatically paying the estimate. However, each of these classes of claims represents a significant exposure to the insurance carrier in terms of the claimant not having coverage for the loss or from an underwriting aspect. Therefore, a claim been designated as either class might be directed internally to a non-automated process no matter how low the claims score.

Detail Description Paragraph:
[0272] In one embodiment, the audit sub-system 240 determines if statutory regulations are satisfied in the processing of the claim thus far. The audit sub-system 240 applies statutory regulations to claim data in a similar fashion to the application of insurance carrier business rules. For example, certain state regulations mandate that certain notifications need to be sent to consumers, while another imposes cycle time limitations on addressing a filed claim. The audit sub-system 240 determines if notifications have been sent and automates the process of sending the notifications if they have not been sent. Also, in the case of statutory regulated deadlines, the audit sub-system 240 generates reminders to responsible parties that a task must be completed by a mandated deadline. The audit sub-system 240 is provided a list of statutory regulations that apply to the claim process the audit sub-system 240 is auditing. Statutory regulations can be edited and updated to reflect changes in the law.

Detail Description Paragraph:
[0274] If no business rule or statutory regulation has been violated, the audit process terminates 1809. If a business rule or statutory regulation violation is detected, the audit sub-system 240 applies business rules to process the violation. The audit sub-system 240 can directly notify third parties involved (e.g., vendors or policy holders) of the violation with explanation as to reason for violation and proposed courses of action. For example, if an estimate submitted by a repair facility provides insufficient or invalid information, the audit sub-system 240 would detect the violation and notify the repair facility to complete or provide additional valid information. Violations resolution is governed by business rules and can require that the audit sub-system 240 notify and transfer the audit process to a human participant such as an insurance carrier appraiser. For example, if instead of determining that an estimate submitted by a repair facility violates business rules by failing to submit sufficient or valid information, the audit sub-system 240 determines that the estimate contains sufficient and valid information, but is unreasonably high, the audit sub-system 240 would assign the audit process to an human participant such as an insurance carrier adjuster to conduct an additional audit, and if the estimate is still found unreasonable, to negotiate with the repair facility to change the estimate. In an alternate embodiment, in the previous example, the audit sub-system 240 could automatically notify the repair facility that their estimate was denied, that it was unreasonable, and with sufficient details of denial such that the repair facility can attempt to make a more reasonable estimate.

Detail Description Paragraph:
[0283] Claim data, including administrative information related to insurance policies, policy holders (such as name, address, policy information, and

transactions), consumers, and other users (e.g., insurance carriers, and vendors), as well as assignments, estimates, digital images, supplements, status of tasks related to the claim, transaction logs and entries, parts lists, warranties, payment information, and reports is stored in the eclaim database 280. In one embodiment, instead of storing detailed vendor related administrative and other data (e.g., CSI) in the eclaim database 280, detailed vendor related claim data is stored in the directory database 290 which is linked to general vendor claim data that is stored on the eclaim database 280. Certain claim data is stored in a format that cannot be edited based on governmental regulatory requirements or due to business rules. For example, initial claim data captured by FNOL 210 or receiving and stored in the eclaim database 280 from insurance carrier systems 65 are frozen so as to prevent fraud. In another example, digital scanned images of legal documents are stored in an uneditable format. However, in one embodiment, copies of this data, which are labeled as copies and not originals, are made and can be edited or manipulated and added to the virtual claim file containing the original data.

Detail Description Paragraph:
[0296] In addition, Deskview 200 allows the user to change or edit or manipulate claim data such as administrative information and digital images to the virtual claim file. FIG. 24B is a screenshot of a user interface and claim management system viewing and editing digital images feature. Claim data such as administrative information and digital images can be appended to the virtual claim file as well. For example, a user utilizing Deskview 200 can enter notes concerning the claim or link emails and other documents to the other claim related data that compose a virtual claim file. Certain claim data is stored in a format that cannot be edited based on governmental regulatory requirements or due to business rules. For example, initial claim data captured by FNOL 210 or receiving and stored in the eclaim database 280 from insurance carrier systems 65 are frozen so as to prevent fraud. However, in one embodiment, copies of this data, which are labeled as copies and not originals, are made and can be edited or manipulated and added to the virtual claim file containing the original data.

Detail Description Paragraph:
[0362] In another embodiment, the reporting sub-system supports the generation of customized reports that match user selected criteria to produced focused results. The reporting sub-system is able generate reports indexed by activity within a specific time range, by activity within a geographical region, and by vehicle type. FIG. 29 is a screenshot of a report generated by a reporting sub-system that is indexed by region and by state within each region. In one embodiment, the reporting sub-system 270 allows a user to drill down and view the specific details of customized reports (e.g., the number of assignments can be presented in a per day, per adjuster, per week, per month, per quarterly and per year format, or by adjuster, by service office, by region, and by insurance carrier). In one embodiment, customized reports are generated by third party systems.

CLAIMS:

12. A computer implemented method for auditing a plurality of data associated with an insurance claim to determine if the insurance claim has been accurately processed comprising: receiving a plurality of data, which includes initial claim data, a transaction history of the claim, estimates, and payment requests; comparing the received data representing the transactional history of claim handling to governmental regulatory requirements to determine if additional action is required; comparing the received data representing the transactional history of claim handling to a plurality of business rules to determine if additional action is required; determining from application of a plurality of business rules to the received data representing generated estimates whether to validate the estimate and if there is a potential for fraud; determining from the application of a plurality of business rules to the received data representing payment requests whether to

validate the payment request and if there is a potential for fraud.

Previous Doc Next Doc Go to Doc#